Important Facts For Part-Time Local 587 Employees

King County
Benefits Operations

This booklet explains:

- How King County administers your benefit plans
- COBRA, family-medical leave and disability accommodation programs
- Your rights and responsibilities under the plans.

Important Facts is provided to all new employees and, when information changes, it's updated and distributed to current employees with open enrollment materials. The information in this edition refers to benefit plans effective January 1, 2003. For more details, please see your benefit plan booklets and guides or contact the resources listed in the Resource Directory on the last two pages.

Every attempt has been made to ensure the accuracy of this information. However, if there is any discrepancy between the information and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Benefit Eligibility

► You

If you're a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of three benefit plans — Plan 1, Plan 2 or Plan 3.

You're also eligible for other county benefits, as explained in Plan 1/2/3 enrollment materials and the Flexible Spending Accounts (FSA) guide. These include:

- Free Flexpass/employee ID and other Employee Transportation Program benefits
- Health and Dependent Care Flexible Spending Accounts
- King County Employees Deferred Compensation Plan
- Making Life Easier Program services, including free and confidential personal counseling, home mortgage assistance, child and elder care referral and mildly sick child care.

You're not eligible for these benefits if you work less than half time or are a temporary or seasonal employee, or if you work in a capacity that, at the discretion of Human Resources, is considered contract labor or independent contracting. If you're not treated as a common law employee by King County for income tax withholding (regardless of any later determination of legal employment status), you're not benefit eligible.

Plan 1. You become eligible the first of the month following your hire date, as determined by your department. If your hire date is the first of the month, you become eligible the same day.

Under Plan 1 you may purchase health coverage (medical, dental, vision) for yourself and family members, plus basic life insurance ($20,000) for yourself. You must elect health coverage for yourself to cover family members; you must elect medical coverage to elect dental.

You pay for Plan 1 benefits through payroll deduction. The monthly cost of benefits is divided in half and deducted from your two regular monthly paychecks. (When there are three paychecks in a month, no deductions are taken from the last one.) You may have the deductions taken before or after federal income and Social Security taxes are withheld.

If you have deductions taken before-tax, this reduces your taxes. However, IRS restrictions apply:

- Any portion you pay to provide coverage to a domestic partner or domestic partner's children is deducted after-tax
- You may not drop any coverage until the next open enrollment unless due to a qualifying change in status:
  - Death of a family member
  - Divorce or dissolution of a domestic partnership
  - Significant change in your spouse's or domestic partner's coverage due to his/her employment
- You must re-enroll for before-tax every year during open enrollment or you default to the after-tax plan.

If you pay for benefits after-tax, you do not reduce your taxes, but may drop coverage for yourself or a family member anytime.

You may change payment plans only during open enrollment.

Plan 2. You become eligible when you receive 338 paid hours in either of two four-month periods:

- November 1-February 28/29 (Plan 2 benefits begin May 1)
- March 1-June 30 (Plan 2 benefits begin September 1).

Plan 2 benefits extend through the end of the calendar year. They continue through the end of the following calendar year if you:

- Receive an average of 39 hours or more per pay period in the 26 consecutive pay periods that end with the pay period including July 31 (you must have been employed as a part-time Local 587 employee for at least the most recent six complete pay periods to qualify for this review) or
- Pick assignments averaging four hours or more for the February, June and September shake-ups (you must have picked assignments for all three shake-ups to qualify for this review).

Under Plan 2, you receive county-paid medical, dental and vision coverage for you and the eligible family members you enroll, plus basic life, accidental death and dismemberment (AD&D), and long term disability (LTD) insurance for you. When you first enroll under Plan 2, you may also purchase additional enhanced life and AD&D for yourself and family members, plus enhanced LTD for yourself.

If you and your spouse/domestic partner are both county employees, you may cover only yourself for enhanced life and enhanced AD&D (you may not enroll each other for spouse/domestic partner coverage), and only one of you may cover your children for enhanced life and enhanced AD&D.

Plan 3. When you lose eligibility for Plan 2, you become eligible for Plan 3.

Under Plan 3 you continue to receive the same county-paid basic life, AD&D and LTD coverage you had under Plan 2 and may continue to purchase enhanced life, AD&D and LTD coverage. If you choose to continue medical, dental and vision coverage for yourself and family members, you pay for the coverage. The rates are the same as Plan 1 coverage.

► Family Members

The following family members are eligible under your coverage if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership must be filed with Benefits Operations)
- Unmarried children of you or your spouse/domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally, that means you claim them on your federal tax return); a child may be your natural child, adopted child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan (see next page).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support; the child must have become incapacitated while covered by the plans and before age 23; an incapacitated child is not eligible for life insurance (to continue an incapacitated child's coverage, you must submit a Continue Coverage for Disabled Adult Child Form to Benefits Operations within 60 days of the child's 23rd birthday and provide proof of the child's continued disability periodically thereafter).

Domestic Partners Under Plan 2. There is no cost for family member health coverage under Plan 2. However, when you cover a domestic partner and domestic partner's children for health benefits (medical, dental, vision), the IRS taxes you on the value of the coverage. The value is added to the salary shown on your paycheck (and W-2 at the end of the year); federal income tax is withheld on the higher salary amount and then the value is subtracted from your salary.

Qualified Medical Child Support Order. In accordance with applicable law, the plans provide medical, dental and vision coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A QMCSO is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- Coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

Benefits Operations promptly notifies you and the alternate recipient when a QMCSO is received and explains what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits Operations notifies you and the alternate recipient(s) by mail.

Appealing Eligibility

► Benefit Eligibility

If you or your family members lose eligibility or are determined ineligible, and you disagree with that decision, you may file a written eligibility appeal to Benefits Operations within 30 days of the event that affected eligibility.

When submitting an appeal, you must include:

- Your name and address, and each family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your Employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

You'll be notified of the appeal decision in writing within 60 days of receiving your request. If you disagree with the decision, you may request a hearing. All eligibility disputes are subject to binding arbitration under American Arbitration Association rules unless you are covered by a collective bargaining agreement that states otherwise.

► Plan Eligibility

If you lose eligibility for one part-time Local 587 benefit plan (Plan 1/2/3), are changed to a different plan and disagree with that decision, you may file a written eligibility appeal to Metro Transit Human Resources within 30 days of receiving notification of the change.

When submitting a plan eligibility appeal, you must include:

- Your name and address
- Plan change notice
- Your Employee ID number (as it appears on your pay stub) or Social Security number
- Reason for the appeal.

You'll be notified of the appeal decision in writing within 30 days of receiving your request. If you disagree with the decision, you may file a grievance with Local 587.

Enrolling in the Plans

You receive enrollment materials for each plan as you become eligible.

If you decide to participate in an flexible spending account (FSA), you must submit the FSA enrollment form included in the FSA guide within 30 days of when your eligibility for Plan 1 or Plan 2 begins (you are not eligible to enroll in an FSA when you change between Plan 2 and Plan 3). Otherwise, you must wait for a qualifying change or the next open enrollment. (You must reenroll each year at open enrollment to continue participating in an FSA.)

Plan 1. You must submit your enrollment form within 30 days of your eligibility date (sooner if possible). Otherwise, you must wait until the next open enrollment to enroll in Plan 1. If you wait, you may not elect basic life insurance.

Open enrollment every October lets you change certain coverage effective the following January. However, if you first enroll for Plan 1 in October, November or December, you're not eligible for that year's open enrollment and your coverage remains in effect through the following calendar year (or you drop it).

Plan 2. You must submit your enrollment form by the deadline indicated in your Plan 2 materials (the materials are mailed to you approximately one month before your Plan 2 eligibility begins). Otherwise, only eligible family members you've previously enrolled in a county medical plan will be covered and you'll receive the following default coverage:

- KingCare (Aetna) Basic Medical or the last county medical plan in which you were enrolled
- Dental
- Vision
- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance
- Basic long term disability (LTD) insurance.

If default coverage is assigned, you:

- Must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add family members for coverage
- May not add enhanced life until certain qualifying changes occur (see "Changes You May Make When a Qualifying Change Occurs").
- May not add enhanced LTD anytime.

Plan 3. You must submit your enrollment form by the deadline indicated in your Plan 3 materials (the materials are mailed to you approximately one month before your Plan 3 eligibility begins). Otherwise, all previous Plan 2 coverage except basic life, basic AD&D and basic LTD for you will end the day before your Plan 3 eligibility begins, and you:

- Must wait until the next open enrollment to add health (medical, dental, vision), elect enhanced AD&D and add family members for coverage
- May not add enhanced life again until certain qualifying changes occur (see "Changes You May Make When a Qualifying Change Occurs").
- May not add enhanced LTD anytime.

When Coverage Begins

► You

For most plans, if you're not actively at work the day you would become eligible, coverage begins when you return to work in a regular position at least half time. For Plan 2 life and LTD, if you're not actively at work because of a physical disease, injury, pregnancy or mental disorder the day before coverage would start, coverage begins when you return in a regular position at least half time and work at least one day of your normal, scheduled work day.

When you change coverage during open enrollment your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

Plan 1. If you enroll, coverage begins the first of the month following your hire date, as determined by your department. If your hire date is the first of the month, your coverage begins the same day.

Plan 2/3. Coverage begins January 1, May 1 or September 1, depending on your eligibility date.

► Family Members

Coverage for your eligible family members does not begin until you submit completed enrollment forms listing them. If you miss the enrollment deadline, you must wait until the next open enrollment or a qualifying change in status to add eligible family members for coverage (see "Changes You May Make When a Qualifying Change Occurs").

Health Coverage. If enrolled by the deadline, medical, dental and vision coverage for your:

- Newborn or newly placed adopted child is retroactive to the date of birth or placement
- New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership; if you marry or establish your domestic partnership on the first day of the month, coverage begins the same day.

Coverage under all medical plans is provided for newborns under the mother's benefits for the first three weeks of life. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled within 60 days of birth.

If your family member is confined in a hospital or other facility at the time coverage would typically begin, coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Plan2/3 Life and AD&D. Children younger than 14 days are not eligible for life or AD&D coverage. If you enroll a newborn, newly placed adopted child or new spouse/domestic partner for life and AD&D, coverage begins the first of the calendar month payroll contributions start (or when a child reaches 14 days of age, if later). However, if your family member is confined in a hospital or other facility at the time coverage would typically begin, coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Making Changes: General Information

The next three sections describe how to make changes to your benefit coverage between first enrolling and leaving county employment. Your change may require supporting documentation and forms:

- Add New Family Member Form
- Affidavit of Marriage/Domestic Partnership
- Beneficiary Update Form
- Continue Coverage for Disabled Adult Child Form
- Delete Family Member Form
- Enhanced Life/AD&D Change Form
- Personal Information Update Form
- Opt Back In Form
- Forms included in the FSA guide.

All guides and forms are available at www.metrokc.gov/ohrm/benefits or from Benefits Operations (see Resource Directory on last two pages).

Changes You May Make Anytime

► Drop Family Members from Coverage

You may drop family members from coverage anytime. If the drop is due to a qualifying change (divorce, termination of domestic partnership, death, child no longer dependent, end of a Qualified Medical Child Support Order), you must submit the form within 60 days of the qualifying event (sooner if possible), and coverage ends the last of the month in which the qualifying event occurs.

To drop family members, you must submit a Delete Family Member Form. For self-paid coverage, Benefits Operations must receive the form by the ninth of the month to stop your payroll deductions by the following month.

Plan 2. If you drop your spouse/domestic partner from health coverage, he/she must have other coverage and consent to being dropped if the drop is not due to a qualifying change (divorce, termination of a domestic partnership or death).

► Drop or Reduce Self-Paid Enhanced Coverage

You must submit a detailed written or e-mail request to Benefits Operations (no form is available) to drop or reduce self-paid coverage. The request must be received by the ninth of the month for the change to take effect the first of the following month.

Plan 1. If you drop medical, dental or vision coverage, you may not add it again until the next open enrollment. If you drop basic life insurance, you may not add it again anytime.

Plan 2 /3. If you drop or reduce enhanced life, you may add or increase it again only when certain qualifying changes occur. If you drop or reduce enhanced AD&D, you may add or increase it again during the next open enrollment. If you drop enhanced LTD, you may not add it again.

Changes You May Make When a Qualifying Change Occurs

► Add Family Members for Health Coverage

You must submit an Add New Family Member Form within 60 days of these qualifying events (sooner if possible) to add a family member for health coverage (medical, dental, vision):

- Birth or placement for adoption of a child
- Placement of a foster child
- Marriage or establishment of a domestic partnership
- Qualified Medical Child Support Order
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

If you do not submit the form within 60 days, you must wait until the next open enrollment to add the family member for coverage.

Health coverage for your:

- Newborn or newly placed adopted child is retroactive to the date of birth or placement. (Medical coverage is provided for newborns under the mother's benefits for the first three weeks of life. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled within 60 days of birth.)
- New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership (as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership).

If your family member is confined to a hospital or other facility at the time coverage would typically begin, health coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

► Change Plan 2/3 Enhanced Life/AD&D Coverage

You must submit an Enhanced Life/AD&D Change Form within 30 days of the qualifying event described for each benefit to change your Plan enhanced life and AD&D coverage.

Enhanced Life. You may add or increase enhanced life for yourself and add a:

- Spouse/domestic partner for enhanced life when he/she:
  - Becomes your new spouse/domestic partner
  - Loses his/her own county coverage
- Child when he/she:
  - Becomes your first eligible child
  - Is the child of a new spouse/domestic partner
  - Is the firstborn or first adopted child of a new marriage/domestic partnership
  - Loses county coverage.

If you don't submit the form within 30 days, you may not add the family member for enhanced life. (You may drop family members from coverage anytime, but if you do, you may not add them back again.)

Enhanced AD&D. If you have enhanced AD&D for yourself, you may add a:

- Spouse/domestic partner for enhanced AD&D when he/she:
  - Becomes your new spouse/domestic partner
  - Loses his/her own county coverage
- Child when he/she:
  - Becomes your first eligible child
  - Loses county coverage.

If you don't submit the form within 30 days, you may not add the family member for enhanced AD&D until the next open enrollment. (You may drop family members from coverage anytime, but if you do, you may not add them back again until the next open enrollment.)

► Request Health Coverage Previously Declined

You must submit an Opt Back In Form within 60 days of losing other coverage (sooner if possible) if you or a family member loses health coverage through another employer and wishes to opt back in under county plans.

If you don't submit the form within 60 days, you may not opt back in under the county plans until the next open enrollment.

If your other coverage is COBRA, it must be exhausted before you can opt in to coverage outside of open enrollment. For other than COBRA coverage, the loss of coverage must be due to divorce, death, termination of employment, reduction of hours or termination of employer contributions toward the other coverage.

► Request Continuation of Coverage for a Disabled Adult Child

Submit a Continue Coverage for Disabled Adult Child Form for a child currently enrolled in county benefits past age 23 if the child chiefly depends on you for support and maintenance and becomes incapacitated by a developmental or physical disability before turning 23. Submit the form six months before the child turns 23 or no later than 60 days after.

Changes You May Make at Open Enrollment

Open enrollment every October lets you make the following changes in coverage without qualifying changes in status:

- Change medical plans
- Add eligible family members not previously covered
- Add or increase enhanced AD&D for yourself and family members (Plan 2/3)
- Change your premium payment plan (Plan1/3)
- Enroll/reenroll in an FSA (you must reenroll each year to continue participating).

Changes you make at open enrollment become effective January 1 of the next year unless you drop family members from coverage or drop or reduce self-paid Plan 1 basic life or Plan 2/3 enhanced life, AD&D or LTD coverage (changes you may make anytime).

Enhanced Life. If you don't enroll for enhanced life insurance when you're first eligible, or drop or reduce enhanced life, you may add or increase it again only when qualifying changes occur. You may not add or increase it during open enrollment.

Enhanced LTD. If you don't enroll for enhanced LTD when you're first eligible, or drop enhanced LTD, you may not add it again.

When Coverage Ends

► You

Your benefit coverage ends the:

- Last day of the month you lose eligibility, resign, are terminated or retire, or fail to make any required payments for self-paid coverage
- Day the plan terminates or you die (life and AD&D coverage ends when you die, but the benefits you have when you die are paid to your beneficiaries as described in the plan booklets).

Life. If you terminate employment with the county (but not if you retire or leave employment due to a disability), you may continue to pay the insurance company directly for the basic and enhanced coverage you had on your last day of employment until you reach age 75.

AD&D. This coverage also ends when you have served more than 30 days in the military (except in the Reserves or National Guard duty for training).

LTD. Unless you're approved for and receiving LTD benefits, that coverage also ends when you enter full-time active duty in any US armed service.

► Family Members

Family member benefit coverage ends the:

- Last day of the month they lose eligibility, your coverage ends or you fail to make any required payments for their coverage
- Day the plan terminates or they die (any life and AD&D coverage ends when they die, but the benefits they have when they die are paid to you as described in the plan booklets).

Health Coverage. Family members may be able to elect continuation coverage under COBRA (page "COBRA").

Life. If family members have life coverage, it also ends when they've served more than 30 days in the military (except in the Reserves or National Guard duty for training) or when a spouse/domestic partner reaches age 70.

If you terminate employment with the county and continue your own coverage, you may continue to pay for a spouse/domestic partner until he/she is 65 and a child until he/she is 19 (23 if solely dependent on you for support).

AD&D. Family member life or AD&D coverage also ends when they've served more than 30 days in the military (except in the Reserves or National Guard duty for training) or when your spouse/domestic partner reaches age 70.

Family-Medical Leave

► Eligibility

If you've worked for King County at least a year (need not be 12 consecutive months) and work 1,250 hours (40-hour work week employees), 910 hours (35-hour work week employees) or 510 hours (part-time Local 587 employees) during the 12 months immediately preceding your leave request, you're eligible to take job-protected leave for certain family and medical reasons. Hours counted toward eligibility must be hours actually worked — vacation and sick leave hours do not count.

Under the Family and Medical Leave Act (FMLA), you're eligible for up to 12 weeks of leave. Under King County Family and Medical Leave (KCFML), you're eligible for up to 18 weeks of leave. However, if you've taken FMLA leave/KCFML during the 12 months immediately preceding your latest request, your maximum allotment is reduced by that amount.

FMLA applies to all county employees. KCFML applies to all nonrepresented employees and represented employees whose unions have agreed to the terms of KCFML. If you have questions about FMLA and KCFML eligibility, talk to your supervisor, personnel or union representative.

► Reasons for Taking Leave

You may take leave for these reasons:

- A serious health condition that makes you unable to perform your job
- Caring for your child after birth, adoption or placement for adoption or foster care
- Caring for your spouse with a serious health condition
- Caring for your or your spouse's son, daughter or parent with a serious health condition
- Under KCFML, caring for a domestic partner or domestic partner's son, daughter or parent with a serious health condition.

A serious health condition is an illness, injury, impairment or physical or mental condition that involves either inpatient care in a hospital, hospice or residential medical care facility or continuing treatment by a health care provider.

► Advance Notice and Medical Certification

You must submit your leave request 30 days in advance when your leave is foreseeable or as soon as possible when your leave is not foreseeable.

You must provide medical certification to support a leave request because of a serious health condition. And if requested, you'll need to submit second or third opinions (at King County's expense) as well as a fitness for duty report to return to work.

► Use of Sick and Vacation Leave

You also must use all your sick leave for your own serious health condition (unless the condition is due to an on-the-job injury). After sick leave is exhausted, you may use vacation and other paid leave if approved.

To care for a family member, you may use sick leave or, if approved, vacation. If you use sick leave, you may reserve up to 80 hours of it for your own future use.

You also need to use all your own sick leave or vacation before using any donated sick leave or vacation.

► When Leave Begins

FMLA leave begins the first day you are off the job. KCFML begins the first day you're no longer being paid from your own sick leave, vacation or other paid leave accruals. (For an on-the-job injury, you may opt to go to unpaid leave status and begin KCFML immediately.)

Leave may be taken on a reduced or intermittent work schedule if approved by your supervisor.

► Continuation of Benefits

Under FMLA or KCFML, county-paid medical, dental and vision benefits continue while you're on leave. If you go on unpaid leave status, you may pay to continue your life insurance to a maximum of 12 months, AD&D to a maximum of six months and LTD up to 18 weeks. Benefits Operations will contact you regarding continuation of benefits when it receives a copy of your leave-granting authority's response to your leave request.

► Job Protection

Upon return from FMLA leave or KCFML, you are restored to your original or equivalent position with equivalent pay, benefits, seniority and other employment terms. You won't lose any employment benefits that accrued before your leave began. No adverse personnel actions may be taken against you for taking FMLA leave or KCFML, but your job is not protected unless you return to work by the expiration date of your leave. Failure to return by the expiration date may be cause for removal and result in termination of your employment.

King County may not interfere with, restrain or deny the exercise of any right provided under FMLA. The county may not discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. The US Department of Labor is authorized to investigate and resolve complaints of violations, and an FMLA-eligible employee may bring a civil action against King County for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Leave of Absence without Pay

If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML leave period on unpaid status, your benefit coverage:

- Continues uninterrupted if your leave is less than 31 days
- May be continued under COBRA if your leave is 31 days or more (county coverage ends the last day of the month you work before the leave begins).

If You Become Disabled

► Accommodation Policy

Under federal (American with Disabilities Act), state and local laws, King County provides reasonable accommodations for you if you are disabled, regardless of how or when you become disabled, or whether the disability is permanent or temporary. Disabilities may be caused by injury, accident or disease, or may have been present since birth.

► What to Do

If you become disabled:

- File a workers' compensation claim with your base chief or supervisor if the disability is work related
- Contact Transit Human Resources
- Apply for family-medical leave with your supervisor if your disability keeps you from working
- File an application for LTD benefits with Benefits Operations if you're going to be off work for an extended period (you must provide proof of your disability within 12 months after your disability begins and annually thereafter; see your LTD plan booklet)
- Contact Associated Administrators Inc. (AAI), King County's FSA administrator, within 30 days of beginning leave due to the disability if you participate in an FSA and your disability alters expected health care expenses (you may be able to change or discontinue your contributions; see your FSA guide)
- Contact the Washington State Department of Retirement Systems to discuss benefit options if your disability keeps you from working
- Contact the Deferred Compensation Plan if you are a participant and your disability has created an unforeseen financial hardship (you may qualify for a hardship withdrawal of funds)
- Apply for Social Security disability income if your disability qualifies.

► Continuation of Health Benefits

Under Family-Medical Leave. If your disability qualifies you for leave under the Family and Medical Leave Act (FMLA), King County Family and Medical Leave (KCFML) or both, your health coverage (medical, dental, vision) continues.

Under Leave of Absence Without Pay. If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML leave period on unpaid status, your health coverage ends and you may be eligible to pay to continue coverage under COBRA.

If you or covered family members in the KingCare (Aetna) Basic or Preferred Medical Plan are totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this medical extension or COBRA coverage, but electing the extension forfeits the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA.

Medical extension coverage will end on the date coverage terminates for the group you were in when you became disabled or on the date you or your family members experience any of the following:

- Reach any lifetime maximum
- Are no longer disabled
- Become eligible for benefits under another group policy
- Reach the end of the 12-month extension.

If you or covered family members in the Group Health plan become disabled, coverage under your county medical plan ends. You may be eligible to continue coverage under a family-medical leave and then under COBRA.

► Continuation of Plan 2/3 Life and AD&D

Life. If you're disabled (as determined by the life insurance plan) and notify Benefits Operations within 30 days of your disability, your basic insurance continues at no cost to you.

If you're totally and permanently disabled before age 60 and notify Benefits Operations within 30 days of your disability, your enhanced life coverage continues at no cost to you (enhanced life premiums are waived) until age 65. If you are disabled at age 60 or older, you may self-pay to continue enhanced life up to 12 months.

AD&D. If you're disabled and notify Benefits Operations within 30 days of your disability, your basic AD&D continues at no cost to you for up to six months after the disability occurs. If you're not disabled and not terminated from county employment, you may self-pay to continue your enhanced AD&D for up to six months while on a leave of absence.

Life and AD&D coverage ends when you:

- Are no longer totally disabled
- Fail to provide annual required proof of disability
- Fail to agree to a required health examination
- Reach age 65 for life insurance or reach the end of six months for AD&D insurance.

If your coverage ends and you don't qualify for this disability provision, you may be eligible to continue life insurance under the portability option and convert your AD&D to an individual policy.

► Continuation of LTD

You may continue your Plan 2/3 LTD coverage under a family-medical leave for up to 18 weeks by paying the premiums. Once your leave ends, you may continue to pay the premiums through the remainder of your LTD benefit waiting period. While you're receiving LTD benefits, you will not be responsible for monthly premiums.

► Job Reassignment and Search Assistance

If you cannot be accommodated in your regular job and are separated from your position, employment placement assistance is provided through the Disability Services Program in two phases, lasting up to nine months. The program will help you:

- Be assigned through a non-competitive hiring process during the first four months
- Find and apply to posted job positions as an internal candidate for an additional five months if reassignment is unsuccessful.

COBRA

► Eligibility

If you or your qualified family members lose county-paid health coverage due to certain events, each of you has an independent right to self-pay under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for health coverage (medical, dental, vision). This coverage may continue for 18 to 36 months after county-paid coverage ends (the last of the month the qualifying event occurs). Length of the COBRA continuation coverage period depends on the event:

- Termination of employment if for reasons other than gross misconduct (18 months)
- Layoff (18 months)
- Reduction in work hours/no longer eligible for county-paid benefits (18 months)
- Disability (29 months if you or family members are determined to be Social Security disabled at the time of or within 60 days of when COBRA eligibility begins due to your termination or reduction in hours; the COBRA participant must provide a copy of the Social Security disability determination to AAI, King County's COBRA administrator, before the end of the first 18 months of COBRA and within 60 days after being determined disabled under Social Security)
- Death (36 months for surviving qualified family members)
- Divorce/dissolution of domestic partnership (36 months for qualified family members)
- Dependent child ceases to be a dependent — no longer claimed as an IRS dependent or reaches age 23 (36 months for child)
- Medicare entitlement (36 months for qualified family members).

If a second qualifying event occurs during an 18- or 29-month COBRA continuation coverage period, coverage may be continued for up to 36 months from the first qualifying event, but the COBRA continuation coverage period will not exceed 36 months.

You and your qualified family members may elect coverage even if covered under another employee-sponsored health plan or entitled to Medicare at the time you elect coverage.

► Enrollment

COBRA-qualifying events (other than divorce, dissolution of a domestic partnership or child reaching age 23) are reported to Benefits Operations through your termination notice or payroll report. For family members who lose coverage through you because of divorce, dissolution of a domestic partnership or child reaching age 23, you must notify Benefits Operations within 60 days of the last of the month the qualifying event occurs or the date coverage ends, if later. Otherwise, the family member will not be offered the option to elect COBRA continuation coverage.

When COBRA-qualifying information is received, Benefits Operations notifies AAI, who contacts you and/or your family members regarding benefit plan options.

You have 60 days after coverage ends to make your COBRA elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect COBRA continuation coverage, you must make the initial payment by the 45th day after electing it. Thereafter, all premiums are due the first of the month or coverage automatically ends 30 days after the payment due date. AAI will give you payment information.

Because COBRA continuation coverage is retroactive there is no lapse in coverage — self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► Options

If you elect COBRA, you self-pay to continue the same health coverage you had on your last day of employment. Your options for continued coverage include:

- Medical, dental and vision
- Medical only
- Dental and vision (only if you were opted out of medical on your last day of employment).

You may continue covering the same family members who were covered the last day of your employment or you may drop any of them from coverage anytime. If you drop family members from coverage, they have their own COBRA rights. However, family members added after you elect COBRA coverage do not have separate COBRA rights, except for newborns and newly adopted children.

Life. It is not a provision of COBRA, but if you terminate employment with the county (not if you retire or leave employment due to a disability), you may continue to pay the insurance company directly for the:

- Basic and enhanced coverage you had on your last day of employment until you reach age 75
- Coverage your family had until a spouse/domestic partner reaches age 65 and a child reaches age 19 (23 if solely dependent on you for support).

To continue this coverage, contact the insurance company.

► Making Changes

If you notify AAI, you may:

- Drop dental and vision and retain medical coverage anytime (notice must be received in the month before you want the change to become effective)
- Drop family members from coverage anytime (notice must be received in the month before you want the change to become effective)
- Add new family members to your health coverage when a qualified change in status occurs (see “Changes You May Make When a Qualifying Change Occurs”)
- Change medical plans during open enrollment.

In addition, you may change medical plans between open enrollments if you move out of your current plan's coverage area, provide proof of your new permanent address, enroll in another King County plan that offers coverage in your new location and notify AAI.

► When Coverage Ends

COBRA coverage ends the:

- Last day of the month you or your family member fails to make the required payments within 30 days of the due date, becomes entitled to Medicare benefits after electing COBRA, reaches the end of your maximum COBRA coverage period or is no longer disabled as determined by Social Security and has exhausted 18 months of COBRA coverage
- Day the plan terminates, you die or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your COBRA continuation coverage will be terminated.
- You do not have to show you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are no longer covered under the county's plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

Retiree Benefits

► Eligibility

County-paid coverage ends the last of the month you retire. You may self-pay to continue medical and vision coverage (but not dental) if you:

- Have county benefits on your last day of employment
- Have worked for King County for at least five consecutive years before you retire
- Are not eligible for Medicare
- Are not covered under another medical group plan
- Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Life, AD&D and LTD coverage (in addition to dental coverage) is not available under retiree benefits.

► Enrollment

Your retirement is reported to Benefits Operations through your termination notice or payroll report. Benefits Operations then notifies AAI, who contacts you regarding benefit plan options.

You have 60 days after coverage ends to make retiree elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect retiree benefits, you must make the initial premium payment by the 45th day after your election. Thereafter, all premiums are due the first of the month, or coverage automatically ends 30 days after the payment due date. AAI will give you payment information.

Because retiree benefit coverage is retroactive there is no lapse in coverage — self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► Options

If you elect retiree benefits, you self-pay to continue the same health coverage you had on your last day of employment. Your options for retiree coverage include:

- Medical and vision
- Medical only.

You may continue covering the same family members who were covered the last day of your employment or you may drop any of them from coverage at any time. If you drop family members from coverage, they have their own COBRA rights.

► Making Changes

If you notify AAI, you may:

- Drop vision and retain medical coverage anytime (notice must be received in the month before you want the change to become effective)
- Drop family members from coverage anytime (notice must be received in the month before you want the change to become effective)
- Add new family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Change Occurs")
- Change medical plans during open enrollment.

► When Coverage Ends

Retiree benefits end the:

- Last day of the month you fail to make the required payments within 30 days of the due date or become entitled to Medicare benefits after electing retiree benefits
- Day the plan terminates, you die or you first become covered under another group health plan after the date of your retiree benefit election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

HIPAA restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your retiree coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your retiree coverage will be terminated.
- You do not have to show you are insurable to choose retiree coverage. However, retiree benefits are subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

If You Leave Employment to Perform Uniformed Service

You need to provide Benefits Operations with written notice both when you leave employment to perform uniformed service (such as in the military) and when you return to employment after uniformed service. While performing uniformed service your benefit coverage may be continued, depending on the circumstances.

If you leave employment to serve in the military on demand of the United States Government, you may be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and King County Ordinance 13377. Call Benefits Operations for more information.

► Continuation of Health Benefits

You may continue your health (medical, dental, vision) coverage up to the shorter of 18 months or the period of your service. Generally, you must pay for the full cost of coverage. To be eligible, you must meet the requirements under USERRA. The Veterans' Employment and Training Administration also is required to assist you. If you don't arrange to continue medical, dental and vision coverage, it will end the last day of the month you leave employment.

► Continuation of Life, AD&D and LTD

Life. You may continue your life insurance up to 12 months by paying the premiums. Unless you make arrangements to continue these benefits, coverage will end the day you leave employment. If you terminate employment, you may continue to pay the insurance company directly for the basic and enhanced coverage you had on your last day of employment until you reach age 75.

AD&D and LTD. You may continue your AD&D coverage up to six months by paying the premiums; you may continue your LTD coverage up to 30 days by paying the premiums. Unless you make arrangements to continue these benefits, coverage will end the day you leave employment.

If You're on a Mutual Aid Assignment

Occasionally, for instance in the case of a natural disaster, you may be asked to work temporarily for another agency in need of extra help. If you need health care while you're working in this situation, you will not pay more for the care because you're outside your usual area.

Submit claims directly to the Manager of Benefits Operations for processing and payment.

If you are on loan to a Borrower under the Northwest Mutual Aid Group Omnibus Agreement, you will continue to be covered under your regular medical, dental and vision plan. If, as a result of this arrangement, you receive services outside of the normal network area covered by your plan, your care will be covered by the county at the network level.

If You Enter Into a Labor Dispute

If you enter into a labor dispute, your King County coverage ends. If your pay is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, you may be able to continue your medical, dental and vision coverage temporarily by paying the full cost:

- Medical, dental and vision coverage for up to 18 months (you may also continue participating in a Health Care FSA by contributing on an after-tax basis; see your Flexible Spending Accounts guide)
- Life and AD&D coverage for up to six months (check with the insurance companies if you want to convert your life and AD&D coverage to individual policies).

If Someone Dies

► You

If you die while a participant in King County benefit plans, your family must provide a death certificate to Benefits Operations. When that occurs, Benefits Operations will assist your family with:

- Completing a claim for any life insurance benefit they're entitled to receive (if death is due to accident, the accident report is required)
- Understanding COBRA and options for continuing the health coverage they had through you
- Submitting claims for reimbursement under an FSA if you were enrolled (see Flexible Spending Accounts guide)
- Counseling and referral through the Making Life Easier Program.

LTD. If you die while on LTD, a lump sum benefit is paid to your eligible survivors. The survivor benefit is three times your last gross monthly benefit. The survivor benefit will first be applied to reduce any overpayment of your claim. A survivor benefit would be payable to any one or more of the following:

- Your spouse/domestic partner for whom you have filed a copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership
- Your unmarried children under age 25
- Any person providing care and support for any of your eligible survivors.

If there is no eligible survivor, no payment will be made.

► Family Member

If your family member dies while you are a participant in King County benefit plans, contact Benefits Operations for assistance with:

- Completing a claim for any life insurance benefit you're entitled to receive (death certificate is required; if death is due to accident, the accident report is also required)
- Completing other benefit forms as required
- Reevaluating your need for an FSA if it’s affected by your family member's death (see Flexible Spending Accounts guide)
- Counseling and referral through the Making Life Easier Program.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. The right to payment under these plans is not subject to attachment or garnishment, and the plans will not honor any assignment of benefits to anyone.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

LTD. Your rights and benefits under LTD are not assignable. In other words, you may not transfer your rights and benefits to another party.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. This means the plans are not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred
- Cooperate fully with the plans in asserting their rights by supplying all information and executing all documents reasonably needed for that purpose.

Any sums collected by or for you or your covered family members by legal action, settlement or otherwise on account of these benefits are payable to the plans only after and to the extent they exceed the amount required to fully compensate your loss. This provision does not apply to LTD.

Recovery of Overpayments

The plans have the right to recover amounts they paid that exceed the amount for which they are liable. These amounts may be recovered from one or more of the following (to be determined by the plans):

- Persons to or for whom the payments were made
- Other insurers
- Service plans
- Organizations or other plans.

These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plans' right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

Termination and Amendment of the Plans

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plans for any reason at any time. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

LTD. Your right to receive LTD benefits for a period of disability that begins while you're covered will not be affected by plan amendment or termination, or termination of your coverage.

Medical Plan Bill of Rights

► Dignity and Respect

You have the right to:

- Be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.
- See your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

► Knowledge and Information

You have the right — and the responsibility — to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your medical care
- Medical condition and health status
- Services and procedures involved in your treatment plan
- Ongoing health care you need once you're discharged or leave the physician's office
- How the plans work (you will find that information in your plan booklet)
- Medication prescribed for you — what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your medical care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your physician otherwise.

► Continuous Improvement

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plans
- Ask your physician to explain or give you more information about any medical advice or prescribed treatment
- Appeal any medical or administrative decisions (see "Appealing a Claim" in your medical plan booklet).

► Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- Refuse treatment — as long as you accept the responsibility and consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for health care
- Refuse to take part in any medical research projects
- Be advised on the full range of treatment options (whether covered under the plans or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You also are responsible to:

- Show your ID card to your physician, hospital or other provider before you receive care
- Give your current provider all previous medical records and submit accurate, complete medical information to all physicians or other providers involved in your care
- Be on time for appointments and let your physician's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let the plan and your primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care
- Tell the plan and your primary care provider (if applicable) about planned health care, such as a surgery or an inpatient stay
- Pay all required copayments when you receive health care.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

Glossary of Terms

AD&D. Accidental death and dismemberment.

Beneficiary. The person or organization you designate to receive any life or AD&D insurance benefits payable at the time of your death.

COBRA. Consolidated Omnibus Budget Reconciliation Act. Implemented in 1986, COBRA allows you to continue your health coverage on a self-paid basis under certain circumstances for a limited time. King County offers no greater COBRA rights than required, except spouse rights are extended to domestic partners.

Disability — Medical. A condition determined to be disabling by the Social Security Administration, Public Employees Retirement System (PERS) or the county-sponsored Long Term Disability Plan.

Disability — Life and AD&D. LTD disability determines disability for life and AD&D.

Disability — LTD. Until LTD benefits have been paid for 24 months, you are disabled if you're unable to perform (with reasonable continuity) the material duties of your own occupation. Thereafter, you will continue to be considered disabled if you're unable to perform (with reasonable continuity) the material duties of any gainful occupation for which you are reasonably qualified by education, training and experience.

FMLA. Family and Medical Leave Act. Implemented in 1993, FMLA allows you to take up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements.

Gross Monthly Benefit. Your monthly LTD benefit before any reduction of other income benefits.

HIPAA. Health Insurance Portability and Accountability Act. Effective in 1996, HIPAA restricts the extent to which group health plans may impose preexisting condition limitations.

KCFML. King County Family and Medical Leave. Passed by King County Ordinance 13377 in 1998 and adopted by most but not all labor unions representing King County employees. Allows you to take up to 18 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements.

LTD. Long term disability.

Mutual Aid Agreement. If you are needed to work temporarily for another agency, this agreement allows certain benefits to continue while you're away from the county.

Open Enrollment. The annual period when benefit eligible employees may join a plan, change plans and add or drop family members' coverage. Some enrollment restrictions apply to life insurance.

QMCSO. Qualified Medical Child Support Order. A decree, judgment or order from a state court (including approval of a settlement agreement) or administrative order that requires benefit plans to include a child in your coverage and make any applicable payroll deductions.

USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994.

Resource Directory

For Questions About ...	Contact ...
Plan 1, 2 or 3 Eligibility	Your Base Chief
General Benefits Open enrollment and making changes Flexible spending account enrollment Life, accidental death and dismemberment and long term disability insurance plan details Alternate formats	Benefits Operations Exchange Building EXC-ES-0300, 821 Second Ave., Seattle 98104-1598 Phone 206-684-1556 ▪ 1-800-325-6165 x41556 ▪ 711 TTY Relay Service Fax 206-684-1925 E-mail kc.benefits@metrokc.gov Web www.metrokc.gov/ohrm/benefits
Medical Identification cards Providers (doctors, hospitals, etc.) Filing claims Other plan details (covered expenses, limitations, exclusions, preauthorization)	KingCare (Aetna) PO Box 14089, Lexington KY 40512-4089 Phone 1-800-654-3250 ▪ 771 TTY Relay Service E-mail kingcare@aetna.com Web www.kingcare.com Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 206-901-4636 ▪ 1-888-901-4636 ▪ 771 TTY Relay Service E-mail info@ghc.org Web www.ghc.org
Prescriptions Identification cards (KingCare members only; Group Health members use medical plan card for prescriptions) Pharmacies Mail order service Drug formulary (covered drugs, including generic, preferred brand and non-preferred brand)	AdvancePCS (separate service for KingCare members) PO Box 853901, Richardson, TX 75085-3901 Phone 1-800-552-8159 ▪ 771 TTY Relay Service Web http://kingcounty.advancerx.com (e-mail by selecting Contact Us) Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 206-901-4636 ▪ 1-888-901-4636 ▪ 771 TTY Relay Service E-mail info@ghc.org Web www.ghc.org
Dental Providers Filing claims Other plan details	Washington Dental Service PO Box 75688, Seattle WA 98125-0688 Phone 206-522-2300 ▪ 1-800-554-1907 ▪ 771 TTY Relay Service E-mail cservice@deltadentalwa.com Web www.deltadentalwa.com
Vision Providers Filing claims Other plan details	Vision Service Plan PO Box 997100, Sacramento CA 95899-7100 Phone 1-800-877-7195 ▪ 771 TTY Relay Service Web www.vsp.com (e-mail through the Web site)
Life Insurance Portability option	Aetna Portability Customer Service Phone 1-800-826-7448 ▪ 771 TTY Relay Service
AD&D Insurance Conversion option	CIGNA Customer Service Phone 206-625-8655 ▪ 771 TTY Relay Service

For Questions About ...	Contact ...
Flexible Spending Accounts Account balances Reimbursement Other plan details	Associated Administrators Inc. PO Box 3199, Portland OR 97208-3199 Phone 1-800-334-4340 ▪ 1-800-428-4833 TDD Fax 1-800-979-8987 E-mail flex@aai-tpa.com Web www.aai-pca.com
COBRA and Retiree Benefits	Associated Administrators Inc. PO Box 3988, Portland OR 97208-3988 Phone 1-800-320-2915 ▪ 1-800-428-4833 TDD Fax 503-979-8987 E-mail cobra@aai-tpa.com
Counseling & Resource Referral Personal, family and work problems Financial and legal matters Child care, elder/adult care	Making Life Easier Phone 1-888-874-7290 ▪ 771 TTY Relay Service (24 hours a day, seven days a week)
Deferred Compensation Enrollment Changes (beneficiaries, contributions, allocations, etc.) Quarterly work site seminars	T. Rowe Price PO Box 17215, Baltimore MD 21297-1215 Phone 1-888-457-5770 ▪ 771 TTY Relay Service
Disability Services Essential job function assessment Job modification	Transit Human Resources King Street Center KSC-TR-0419 201 S. Jackson St., Seattle WA 98104 Phone 206-684-1204 ▪ 771 TTY Relay Service
Washington State Retirement System General information Beneficiary designation Beneficiary and address changes Disability benefit options	Washington State Department of Retirement Systems PO Box 48380, Olympia 98504-8380 Phone 1-800-547-6657 ▪ 360-664-4700 ▪ 360-586-5450 (TTY) E-mail recep@drs.wa.gov Web www.wa.gov/drs/drs.html
Workers' Compensation On-the-job illness or injury Benefits Claims	Safety & Claims Management Boeing Field AIR-HR-0103 PO Box 80283, Seattle WA 98108 Phone 206-296-0510 ▪ 1-800-325-6165 x60510 ▪ 771 TTY Relay Service Fax 206-296-0514 Intranet ohrm.metrokc.gov/safety/claiminfo/comphome.htm